M.E. Medical Office
Mashallah Ezzati, M.D.

Progress Note

Patient Name: Allen, Joseph DOB: 5/30/76 Date 6/11/04

S: 28yf/d/w/m with History of using oxycontine 80-160 mg Daily. Last Dose 14th from to this Visit. Denies other Drug abuse Denies any Medical Illness. N.K.A. C/O Irritability and agitation. Achy

O: G.A. Calm, Flushed. nervous.
HEENT: Pupils 3-4 mm Dilated, Reactive
Neurological Examination: Agitated, nervous.
No Focal disorder. Heart S1-S2 Reg.
Lungs clear. Abdome F.W.N.L
BP 140/90 P=72 R=18 T=97° HT=6-2 WT=240

A. Opiate Dependency - Mild W.D.

P: Initiated Tx Methadone + taper
RTC 6/29/04 for F/U

M.E. Ezzati

Mashallah Ezzati, M.D.

I Joseph Lamen am aware that I will be treated with prescription medications for the complications of substance abuse and dependency. I am also aware that these medications may cause dependency.

Joseph Balasciano is my supporter and has my permission to participate in my treatment and exchange information with the practitioner about my health and health care. He/She can be reached at _____ and/or _____.

Staffier's Associates reserves the right to refuse treatment if I decide not to have a support person.

The practitioner reserves the right to refuse treatment to patients displaying disruptive behavior, are verbally or physically abusive or patients requesting treatment as a couple.

Patients with complicated medical or mental problems may be referred to, and treated, as inpatient at other medical facilities.

By signing this contract I acknowledge that:

- I agree to comply with medications and schedules as directed by the practitioner. Otherwise, the practitioner reserves the right to refused additional medications.
- I am responsible for the protection and safety of my medications and NOT to share them with other persons.

Mashallah Ezzati, M.D. is under no obligation to provide me with prescriptions or refills by telephone call. Staffier's Associates has a written prescription policy.

I am aware of the legal consequences for tampering, copying, stealing or calling for prescriptions to the pharmacy.

- I will not operate a motor vehicle or machinery while taking these medications.
- I agree to provide urine specimens at each office visit for toxicology tests. I am aware that if I tamper with the urine toxicology specimens, Staffier's Associates reserves the right to terminate my treatment.
- I understand that if I am not compliant with any of the aforementioned items, the contract will be terminated by Staffier's Associates and I will be responsible for the arrangement of alternate treatment.

Mashallah Ezzati, M.D.

Patient (signature) Joseph Lamen Date: 6-11-04

Support (signature) _____ Date: _____

Practitioner (signature) M. Ezzati Date: 6/11/04

Patients have the right to:

- Respectful care: Staff should respect the dignity of the patient and be sensitive to patient needs. Treatment must be provided regardless of race, religion, national origin or, in emergencies ability to pay.
- Information about future medical care (advanced directives) in the event patient becomes physically or mentally unable to make decisions.
- Complete, up to date information about patient condition, treatment and chances for recovery, and to review medical records.
- Refuse or accept medical treatment if patient is a legally competent adult.
- Informed consent: patient must give written permission for procedures, tests or treatment and be given specific information about them.
- Privacy and confidentiality of all communications and medical records except to those persons directly involved in patient care.
- Acceptance for treatment unless there is good reason for refusing treatment (necessary equipment not available, hospital or health care provider not qualified to treat a particular condition, etc.)
- Information about affiliation of hospital and physician(s) with other institutions and physicians.
- Refuse experimental treatment or participation in research.
- Information about patient's bill: patient has the right to copy of bill and itemization of all charges and charges billed to the insurance company.

Adapted for Primary Care Associates from A Patient's Bill of Rights, American Hospital Association.

PLEASE ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THESE PATIENTS RIGHTS WITH YOUR INITIALS JMA

BUPRENORPHINE MAINTENANCE TREATMENT

PATIENT RESPONSIBILITIES

JmA **The patient will agree to store medication properly.** Medication may be harmful to children, household members, guests, and pets. The pills should be stored in a safe place, out of reach of children. If anyone besides the patient ingests the medication, the patient must call the poison control center or 911 immediately.

JmA **The patient will agree to take the medication only as prescribed.** The indicated dose should be taken daily, and the patient must not adjust the dose on his or her own. If the patient wishes a dose change, he or she will call the clinic for an appointment to discuss this, and the physician can change the order.

JmA **The patient will agree to comply with the required pill counts and urine tests.** Urine testing is a mandatory part of office maintenance, and the patient must be prepared to give a urine sample for testing at each clinic visit no medication.

JmA **The patient will agree to notify the clinic immediately in case of lost or stolen medication.** If a police report is filed, patient must bring in a copy for the record.

JmA **The patient will agree to notify the clinic immediately in case of relapse to drug abuse.** Relapse to opiate drug abuse can be life threatening, and an appropriate treatment plan has to be developed as soon as possible. The physician should be informed about a relapse before any urine test shows it.

JmA **The patient will review the description of office maintenance at this site.** This description includes the hours, the phone numbers, the procedure for making appointment, the fees, the relationship to the methadone maintenance program, the requirements for participation in office maintenance, and the clinic's responsibilities for patient care.

(Patient signature)

WITNESS M. Saffod MD **DATED** 8/11/04

BUPRENORPHINE MAINTENANCE TREATMENT

INTAKE HISTORY AND PHYSICAL

PATIENT'S NAME Joseph Allen DATE 6-11-04

CC: _____

Opiate abuse history:

Yrs/mos of use 2. Type of use ___. Current run of continuous use ___.
Amount of current use _____. Last use date/time _____.
Present symptoms _____

History of drug abuse treatment: _____

Medical history:

Allergies NO Current meds NO
Medical/ psychiatric problems NO
Hospitalization/surgery NO
Hepatitis NO SBE _____ HIV _____ TB _____ STD _____
(women) LMNP _____ G__ P__ TAB__ SAB___ Contraception _____
ROS: _____

Other drug abuse history:

Cocaine/stimulant _____ Alcohol _____
Valium/sedatives _____ Caffeine _____
Marijuana ✓ Nicotine/cigarettes ✓ quit/cut down? _____

Nutrition history: _____

Routine screening history(pap, chol, etc.): _____

PHYSICAL EXAMINATION:

T ___ P ___ BP ___ R ___ WT. ___ HT ___ Gen. Appearance: _____

HEENT: _____ ABD _____
Thyroid/neck _____ BACK _____
Heart _____ Neuro _____
Lungs _____ Extrem _____
Chest/breast _____ Skin _____

Signs withdrawal:
Pupils _____
Rhinorrhea ___
Lacrimation ___
Perspiration ___
Pilorection ___
Increase temp. ___
Increase BP ___
Tachycardia ___
Vomiting ✓
Diarrhea ✓

Sketch of tracks, needle marks and scars:

(Intake h/p, over)

Office-based opioid maintenance assessment:

__opioid dependence
___withdrawal: degree _____

PLAN:

__admit to maintenance treatment; initial dose order: _____
___routine labs; other labs: _____
__TB test; placed date _____ to be read date _____
other TB status checks _____
__ drug screen schedule _____

Next visit: _____

Counseling plans: _____

Signed Joseph M Allen Date 6-11-04

Patient name JOSEPH ALLEN

PATIENT REGISTRATION

NAME: (L) [redacted] Allen (F) Joseph (MI) M

DOB: 5/30/78 AGE: 26 SOCIAL SECURITY NUMBER: 029-58-2491

ADDRESS: 8 Reservoir Rd APT:

CITY: Gloucester STATE: MA ZIP CODE: 01930

PHONE: home (978) 479-6192 work ext.

Marital Status: Single Employed: ☐ Yes ☑ No ☐ FT Student: ☐ Yes ☐ No ☐ FT

Primary Care Physician (L) (F)

ADDRESS:

PHONE:

Employer: School:

Who may we thank for referring you to our practice:

In case of an emergency please contact: Alicia Parisi

Phone: (978) 281-3285 Relationship: GirlFriend

INSURANCE INFORMATION

1ST INSURANCE:	ID #	GROUP #
Subscriber:	DOB: / /	RELATIONSHIP TO PATIENT:
2ND INSURANCE:	ID #	GROUP #
Subscriber:	DOB: / /	RELATIONSHIP TO PATIENT:

I authorize the release of any medical or other information necessary to process my claims for services provided to me at your offices. I also authorize insurance payments to be made directly to Preventive Medicine Assoc., Inc. I understand that I am always personally responsible for all deductibles, coinsurance, copays and for all claims not paid by my insurance. I am also responsible for all lab or incidental charges incurred at the time of all visits that my insurance does not pay.

Joseph M Allen
Patient Signature

6-11-04
Date:

Insurance Card copied by:

My Copay is: $

CONSENT FOR RELEASE OF INFORMATION

I, Joseph Allen (patient name), born on 5-30-78 (patient birth date)

SSN 029-58-2491 (patient social security #), authorize _____ (clinic or doctor's name) to

disclose to _____ (name and location of person/ organization to receive information)

the following information: _____.

The purpose of this disclosure is: _____.

This authorization expires on: _____, or

whenever _____ is no longer providing me with services.

I understand that my records are protected under the Federal regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Signature of patient Joseph m Allen Dated 6-11-04

Signature of witness _____ Dated _____

ATTENTION RECIPIENT:
Notice Prohibiting Redisclosure

This information has been disclosed to you from the records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

How to take your Subutex or Suboxon

1. Wait until you start going into withdrawal
2. Take 4mg Subutex or Suboxon (under your tongue, Do NOT swallow).
3. After 30 to 60 minutes you should feel better. Signs and symptoms of withdrawal should clear.
4. After 1-2 hours you may start having withdrawal again.
5. At this time take a second 4mg Subutex or Suboxon (under your tongue. Do NOT swallow). During the first 24 hours do not take more than 8mg (4mg x 2) Subutex or Suboxon.
6. After 2-3 hours of your second 4mg Subutex or Suboxon, if you still experience withdrawal, start taking your comforting medication from the prescription that has been faxed to the pharmacy.
7. During the second day of your treatment you will receive more information and instructions in the office. However, do not take more than 12mg Subutex or Suboxon during your second day.
8. Please feel free to call for any information.

Wait until Wheatily sick
take 1/4 tablet under tounge
Wait 30 min Feel better OR not WORSE then before
At this time take other 1/4 Wait 1 hour
NOW I should Feel ~~bad~~ better if not

Consent for Treatment with Buprenorphine

Sample

Buprenorphine is an FDA approved medication for treatment of people with opiate dependence. Qualified physicians can treat up to 30 patients for opiate dependence. Buprenorphine can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary.

Buprenorphine itself is an opiate, but it is not as strong an opiate as heroin or morphine. Buprenorphine treatment can result in physical dependence of the opiate type. Buprenorphine withdrawal is generally less intense than with heroin or methadone. If buprenorphine is suddenly discontinued, some patients have no withdrawal symptoms; others have symptoms such as muscle aches, stomach cramps, or diarrhea lasting several days. To minimize the possibility of opiate withdrawal, buprenorphine should be discontinued gradually, usually over several weeks or more.

If you are dependent on opiates, you should be in as much withdrawal as possible when you take the first dose of buprenorphine. If you are not in withdrawal, buprenorphine can cause severe opiate withdrawal. For that reason, you should take the first dose in the office and remain in the office for at least 2 hours. After that, you will be given some tablets to take at home. Within a few days, you will have a prescription for buprenorphine that will be filled in a pharmacy.

Some patients find that it takes several days to get used to the transition from the opiate they had been using to buprenorphine. During that time, any use of other opiates may cause an increase in symptoms. After you become stabilized on buprenorphine, it is expected that other opiates will have less effect. Attempts to override the buprenorphine by taking more opiates could result in an opiate overdose. You should not take any other medication without discussing it with me first.

Combining buprenorphine with alcohol or some other medications may also be hazardous. The combination of buprenorphine with medication such as Valium, Librium, Ativan has resulted in deaths.

The form of buprenorphine (Suboxone) you will be taking is a combination of buprenorphine with a short-acting opiate blocker (Naloxone). If the Suboxone tablet were dissolved and injected by someone taking heroin or another strong opiate, it would cause severe opiate withdrawal.

Buprenorphine tables must be held under the tongue until they dissolve completely. Buprenorphine is then absorbed over the next 30 to 120 minutes from the tissue under the tongue. Buprenorphine will not be absorbed from the stomach if it is swallowed.

Buprenorphine will cost $5-10/day just for the medication. If you have medical insurance, you should find out whether or not buprenorphine is a benefit. In any case, my office fees must be kept current.

Alternatives to buprenorphine

Some hospitals that have specialized drug abuse treatment units can provide detoxification and intensive counseling for drug abuse. Some outpatient drug abuse treatment services also provide individual and group therapy, which may emphasize treatment that does not include maintenance on buprenorphine or other opiate like medications. Other forms of opiate maintenance therapy include methadone maintenance. Some opiate treatment programs use naltrexone, a medication that blocks the effects of opiates, but has no opiate effects of its own.

JOSEPH ALLEN — Print Name

Signature

Date: 6-11-04